STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 01 B. WING	09/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN47932

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/26/11 Facility Number: 000128 Provider Number: 155223 AIM Number: 100289650 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, The Waters of Covington was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully	K0000	Preparation and/or execution of this Plan of Correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors, sleeping rooms and spaces open to the corridors. The facility has a capacity of 119 and had a census of 102 at the time of this survey. Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/29/11. The facility was found not in compliance with the aforementioned requirements as evidenced by:			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to provide automatic door closers and latches on hazardous room doors in 3 of 11 smoke compartments. Sprinklered hazardous areas are required to	K0029	**K-029** It is the intent of this facility to insure automatic door closers and latches on hazardous room doors in 3 of 11 smoke compartments. A. Corrective Action Taken: 1. The facility has installed self-closing devices and latches on all hazardous room doors - South Skilled Shower	10/25/2011

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	be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. The areas of deficient practice could affect visitors, staff and 40 or more residents in the north ICF, the center dining room, and south skilled smoke compartments. Findings include: Based on observations with the maintenance director on 09/26/11 between 10:00 a.m. and 1:40 p.m.: a. The south skilled shower room was used for the collection of soiled linen and trash receptacles. The door was not self closing. b. The soiled laundry access door had no latch. c. The medical records office and storage room access door had no self closer. Records were stored in combustible plastic bins and cardboard cartons in the room. d. The north ICF brute storage room housing two large brute storage containers for the collection of soiled linens and trash did not latch.		Room, Soiled Laundry access door, Medical Records Office and Storage Room access door, North ICF Brute Storage Room – to meet set standards. 2. Medical will be stored in a manner to meet such standards.B. Others Identified: 1. All other hazardous areas of the facility were inspected for this deficiency and all complied with the set standards. C. Measures Taken: 1. The Maintenance Supervisor/designee will review all hazardous room doors to insure self-closing and latching mechanisms are in working order according to set standards. This will be done monthly as a part of the Preventive Maintenance Program. D. How Monitored: 1. The CEO/designee will review the results of the monthly audits at the quarterly QA & A Committee meetings. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is 10/25/2011.	

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	The maintenance director acknowledged at the time of observations the doors to these hazardous areas were not closing and latching as required. 3.1-19(b)			
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 12 exit doors equipped with magnetic locks, was readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily	K0038	**K-038** It is the intent of this facility to insure the means of egress through 1 of 12 exit doors equipped with magnetic locks, is readily accessible for residents without a clinical diagnosis requiring specialized security measures. A. Corrective Action Taken: 1. Maintenance Supervisor replaced the 9 volt battery and also posted information to achieve the pass code to override the lock in the event of equipment malfunction. B. Others Identified: 1. Maintenance Supervisor tested all other emergency exit doors and no other issues were found. C. Measures Taken: 1. Maintenance Supervisor/designee will do a visual and functional test of all emergency exit doors to verify they meet set standards monthly as a part of the Preventive Maintenance Program.	10/25/2011

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	unlock such doors at all times. This deficient practice affects visitors, staff and 27 residents on the Horizons unit. Findings include: Based on observation with the maintenance director on 09/26/11 at 12:10 p.m., the south emergency exit door on the Horizon unit was magnetically locked. A keypad adjacent to the door frame was identified by the maintenance director as the override for the magnetic lock and a code to unlock the door was posted. However, when the posted code was entered, the door remained locked. The maintenance director attempted to unlock the door using the posted code and it failed to unlock. He then entered another code which allowed the door to open. He said at the time of demonstration, the keypad had a nine volt battery backup and if the battery was "low" the code memory would revert back to the original manufacturer's code setting. He said when asked, staff working on the unit with residents would not		D. How Monitored: 1. The CEO/designee will review the results of the monthly audits at the quarterly QA & A Committee meetings. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is 10/25/2011.	

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	know how to override the lock if the door lock failed to release upon activation of the fire alarm and the posted code did not allow the door to unlock. 3.1-19(b)			
K0048 SS=F	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire safety plan addressing all items required by NFPA 101 - 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants in the event of an	K0048	**K-048** It is the intent of this facility to insure the provision of a complete written fire safety plan addressing all items required by NFPA 101. A. Corrective Action Taken: 1. The facility has revised the Disaster Manual to include policy and procedure to respond to battery-powered smoke detectors and alarms and revised the RACE procedure directions to meet set standards. B. Others Identified: 1. All occupants have the potential to be affected. C. Measures Taken: 1. All staff were inserviced on the revisions to the Disaster Manual. D. How Monitored: 1. The Maintenance Supervisor/designee will review revisions and procedures at monthly fire drills. 2. The CEO/designee will review the fire drill documentation at the quarterly QA & A	10/25/2011

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	emergency when the written fire plan should be immediately available. Findings include: Based on a record review with the maintenance director on 09/26/11 from 10:35 a.m. to 11:40 a.m., required elements of the policy and procedure for the written Fire Plan were missing and/or found in different and separate places. The policy and procedure for response to battery smoke detector alarms was not included in the disaster plan. The maintenance director had the policy in a binder he kept. He acknowledged at the time of record review, the policy was not included in the facility disaster manual provided at nurses' stations. The RACE procedure was an element of the Fire Plan but it included conflicting directions to E: evacuate on page 13 of the fire plan and E:extinguish on page 14. Additionally, no policy addressed the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen hood extinguishing system. Interviews with the cook		Committee meetings. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is 10/25/2011.	

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	and food prep staff on 09/26/11 at 12:50 p.m. revealed they had not been trained in the special requirement for use of the K class extinguisher. The review date for the Fire Plan in the disaster book was 2011 and a posted plan was noted to be 2004. The maintenance director acknowledged the inconsistencies noted during the record review and tour. 3.1-19(b)			
K0051 SS=F	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems	K0051	**K-051** It is the intent of this facility to insure to maintain 1 of 1 fire alarm systems in accordance with NFPA-72. A. Action Taken: 1.	10/25/2011

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	in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff. Findings include: Based on observation with the maintenance director on 09/26/11 at 12:10 p.m., the fire alarm system circuit breaker located in the emergency power breaker box lacked identification. In addition the breaker box was unlocked and the door for the mechanical room housing the breaker box was unlocked. The maintenance director said at the time of observation, he was not aware the fire alarm circuit breaker was to be identified and the access door secured. 3.1-19(b)		The Maintenance Supervisor has clearly identified the fire alarm circuit breaker that controls emergency power to the fire alarm system to meet set standards. 2. The Maintenance Supervisor has installed a store-room function door lock set to insure the Mechanical Room door is locked at all times. B. Others Identified: 1. There is no other emergency power breaker boxes. C. Measures Taken: 1. Maintenance Supervisor/designee monitor for proper breaker identification and that the Mechanical Room is locked upon weekly rounds. D. How Monitored: 1. The CEO/designee will review the results of the weekly rounds results at the quarterly QA & A Committee meetings. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is 10/25/2011.	

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K0062 SS=E	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observation and interview, the facility failed to ensure sprinkler heads providing protection in 3 of 11 smoke compartments and protected areas were maintained. This deficient practice affects visitors, staff and 20 or more residents in the south Fountain unit, the dining room smoke compartment, the entry, and the center skilled smoke compartment. Findings include: a) Based on observation with the maintenance director on 09/26/11 between 10:00 a.m. and 1:40 p.m. sprinkler head escutcheons were missing and/or displaced in the south Fountain unit janitor's closet, the medical records storage room near the Fountain unit nurses' station, the main dining room, and the physical therapy room. b) Based on observation with the maintenance director on 09/26/11	K0062	**K-062** It is the intent of this facility to insure that sprinkler heads providing protection in 3 of 11 smoke compartments and protected areas are maintained and insure 1 of 1 sprinkler heads protecting the Activity Room Storage Room has a minimum separation of 4 inches from the wall.. A. Action Taken: 1. The Maintenance Supervisor and a licensed sprinkler contractor have repaired escutcheons and replaced all missing escutcheons and have repaired the front entrance canopy to meet set standards. 2. A licensed sprinkler contractor has relocated the sprinkler head in the Activity Room Storage Room to meet set standards. B. Others Identified: 1. All other areas of the building were inspected to insure compliance with set standards and no other issues were found.. C. Measures Taken: 1. Maintenance Supervisor/designee will complete audits regarding the above cited deficiencies as a part of the monthly Preventive	10/25/2011

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	at 1:35 p.m., one sprinkler providing protection under the entrance canopy was missing. The space was filled in with a caulking material. The maintenance director said at the time of observation, there should be enough protection with the sprinklers provided. He could provide no documentation from the sprinkler contractor which would support his opinion. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads protecting the activities room storage room had a minimum separation of four inches from a wall. NFPA 25, 4-7.3.3 requires sprinklers shall be located a minimum of four inches from a wall. This deficient practice could affect staff, visitors and four or more residents in the activities room. Findings include: Based on observation with the maintenance director on 09/26/11		Maintenance Program. D. How Monitored: 1. The CEO/designee will review the results of the monthly audits at the quarterly QA & A Committee meetings. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is 10/25/2011.	

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	at 12:55 p.m., a single sprinkler head provided protection for the storage room in the activities room. The sprinkler was located two and one fourth inches from the wall separating it from the activities room. The distance was measured with and acknowledged by the maintenance director to be less than the minimum four inches allowed.			
K0064 SS=D	3.1-19(b) Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to maintain 1 of 2 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the	K0064	**K-064** It is the intent of this facility to insure that 1 of 2 portable fire extinguishers in the kitchen cooking area is maintained in accordance with the requirements of NFPA 10. A. Corrective Action Taken: 1. The Maintenance Supervisor has installed a placard next to the K-Class fire extinguisher located in the kitchen area to meet set standards. B. Others Identified: 1. The facility has only 1 K-Class fire extinguisher. C. Measures Taken: 1. The Maintenance Supervisor/designee will audit the K-Class fire extinguisher to meet set standards as a part of the monthly Preventive Maintenance Program. D. How Monitored: 1. The CEO/designee will review the results of the monthly audits at	10/25/2011

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	extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect 20 or more residents using the main dining room, located adjacent to the kitchen. Findings include: Based on observation with the maintenance director on 09/26/11 at 12:40 p.m., no placard was in place above the K class fire extinguisher located in the kitchen to notify occupants it was not to be used until after the fixed fire extinguishing system had been activated. The maintenance director said at the time of observation, he was unaware of the need for the placard. 3.1-19(b)		the quarterly QA & A Committee meetings. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is 10/25/2011.	

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K0066 SS=E	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation, record review, and interview, the facility failed to provide a complete, and enforce, an effective smoking policy for 1 of 2 smoking areas. This deficient practice could affect 4 staff, visitors and any resident in the designated outdoor smoking area located between the kitchen and north skilled unit. Findings include: Based on record review with the maintenance director on 09/26/11	K0066	**K-066** It is the intent of this facility to insure the provision of a complete and enforcement of an effective smoking policy for 1 of 2 smoking areas. A. Corrective Action Taken: 1. The identified smoking areas have been cleaned and ashtrays of non-combustable material and safe design are provided in designated smoking areas. B. Others Identified: 1. All designated smoking areas have been audited to meet set smoking standards.	10/25/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	at 10:35 a.m., the undated facility Smoking Policy noted smoking was permitted in outside designated areas. The policy noted the "designated area for smoking is located outside to include an appropriate receptacle". The maintenance director said the receptacles were the means by which these designated areas could be identified. The smoking area between the kitchen and north skilled unit was observed with the maintenance director on 09/26/11 at 12:15 p.m. The area had two self closing metal ashtrays on two of three picnic tables and a noncombustible smoking tower outside the service corridor exit providing access to the area. The ground surrounding the picnic tables was carpeted with cigarette butts. Ashtrays on two unoccupied tables were full. One unoccupied table had a cigarette butt lying upon it. A third table was occupied by four staff who were smoking and had no ashtray. Staff were observed flicking cigarette ash onto the ground and one staff had a styrofoam plate with a cigarette butt on it. She was smoking		C. Measures Taken: 1. The CEO/designee will audit designated smoking areas weekly to meet set standards D. How Monitored: 1. All audit results will be reviewed at the quarterly QA & A Committee meetings. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is 10/25/2011.	

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	155223	A. BUILDING 01 B. WING	09/26/2011

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	another cigarette. The maintenance director said at the time of observation, he picked up the cigarette butts from the ground but agreed it did not appear so and "there should have been" an ashtray on the smoker's table. 3.1-19(b)			
K0068 SS=E	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 4 boiler/service water heater (SWH) rooms was provided with outside intake combustion air for a room housing fuel fired equipment. This deficient practice could affect visitors, staff and 8 residents in the center skilled smoke compartment. Findings include: Based on observation on 09/26/11 at 12:20 p.m. with the maintenance director, a fuel fire SWH was housed in a room in the center skilled smoke compartment. There was no fresh air intake. The maintenance	K0068	**K-068** It is the intent of this facility to insure that 1 of 4 boiler/service water heater rooms are provided with outside intake combustion air for a room housing fuel-fired equipment. A. Corrective Action Taken: 1. The Maintenance Supervisor has installed a fresh air intake to meet set standards. B. Others Identified: 1. All other boiler/service water heater rooms were audited to meet set standards. C. Measures Taken: 1. The Maintenance Supervisor/designee will conduct monthly audits to insure set standards are met as a part of the monthly Preventive Maintenance Program. D. How Monitored: 1. The CEO/designee will	10/25/2011

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	director acknowledged at the time of observation the room had no fresh air intake. 3.1-19(b)		review the results of the monthly audits at the quarterly QA & A Committee meetings. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is 10/25/2011.	
K0076 SS=E	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure a resident room in 1 of 11 smoke compartments used to store oxygen was separated by construction with a one hour fire resistance rating. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a) requires at least one hour fire resistant enclosures shall be provided for the storage of oxidizing agents such as oxygen. This deficient practice affects staff, visitors and 12 residents in the north skilled smoke compartment.	K0076	**K-076** It is the intent of this facility to insure that 1 of 11 resident rooms smoke compartments used to store oxygen is separated by construction with a 1-hour fire resistance rating. A. Corrective Action Taken: 1. The facility has corrected Room 47 to meet set standards. B. Others Identified: 1. An audit of all other rooms has been completed to insure compliance with set standards. C. Measures Taken: 1. The Director of Nursing/Designee will audit all resident rooms weekly to insure they meet set standards	10/25/2011

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	Findings include: Based on observation with the maintenance director on 09/26/11 at 11:55 a.m., three liquid oxygen containers (181 L capacity) and one e-cylinder were observed in resident room 47. The unrated door was not equipped with a self closer and the walls and ceiling did not provide a one hour fire resistance rating required for oxygen storage areas. A nasal cannula was attached to one liquid oxygen container and was in use by the resident. Nurse #1 was asked at the time of observation why there were so many oxygen containers in the room. She said the resident had the tanks attached to one another to use two tanks at the same time. She was notified this was not the arrangement in use and she inspected the oxygen in use and agreed the oxygen provided to the resident was supplied by one container. She said she was unaware the resident had no need for two containers at one time in the room.		D. How Monitored: 1. The CEO/designee will review the results of the audits at the quarterly QA & A Committee meetings. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is 10/25/2011.	

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K0130 SS=F	3.1-19(b) OTHER LSC DEFICIENCY NOT ON 2786 1. Based on record review, observation and interview, the facility failed to maintain 2 of 2 swinging fire door sets protecting the kitchen in accordance with NFPA 80, 1999 Edition, Standard for Fire Doors and Fire Windows. NFPA 80, 2-1.2 requires fire door assemblies shall consist of components that are separate products incorporated into the assembly and allowed to have their own subcomponents including a latch. NFPA 80, 2-1.4.1 requires self closing fire doors swing freely and easily with a self closing device to cause each door to close and latch upon activation of the fire alarm. This deficient practice affects staff, visitors and and 20 or more residents in the dining room. Findings include: Based on observation with the maintenance director on 09/26/11 at 1:00 p.m. two service windows between the kitchen and main dining room were protected by	K0130	**K-130** It is the intent of this facility to insure that 2 of 2 swinging fire door sets protect the kitchen in accordance with NFPA 80 and to insure 3 of 3 service water heaters have current certificates of inspection. A. Corrective Action Taken: 1. A certified contractor has repaired the swing fire door sets to meet set standards. 1. All water heaters have been inspected by a certified contractor to meet set standards. B. Others Identified: 1. The facility has only 1 kitchen area and no other doors are affected. 2. All water heaters have been checked to meet set standards. C. Measures Taken: 1. The Maintenance Supervisor/designee will audit the 2 swing fire door sets and water heater inspection certificates monthly as part of the Preventive Maintenance Program. D. How Monitored: 1. The CEO/designee will review the results of the monthly audits at the quarterly QA & A Committee meetings. E. This plan of correction constitutes our credible allegation	10/25/2011

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	swinging fire door sets held open by magnets which released upon activation of the fire alarm system. Only one door in each door set was equipped with a latch. In addition, both door sets failed to close and latch when released from their magnetic hold open devices. The maintenance director acknowledged at the time of observation, these doors could not provide protection for the dining room in the event of a kitchen fire. 3.1-19(b) 2. Based on observation, record review, and interview, the facility failed to ensure 3 of 3 service water heaters (SWH) had unexpired certificates of inspection. LSC 19.1.1.3 requires all health facilities to be maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects visitors, staff and 10 or more residents, and occupants of the basement where 3 staff were working in the laundry.		of compliance with all regulatory requirements, our date of completion is 10/25/2011.	

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	Findings include: Based on observation of SWH rooms with the maintenance director on 09/26/11 between 10:00 a.m. and 1:40 p.m. posted certificates of inspection had expired on 08/18/11 for vessels #290018, #262766, #262767 in the sprinkler mechanical room and activities room. One other SWH accessed from an exterior building entry door near the generator was also expired. The maintenance director said at the time of observation, the inspection arrangements were to be made by the regional maintenance director and had not been done.			
K0144 SS=F	3.1-19(b) Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed,	K0144	**K-144** It is the intent of this facility to insure that 1 of 1 emergency generators is equipped with a remote manual stop. A. Corrective Action Taken: 1. A licensed generator contractor has installed an	10/25/2011

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	tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation with the maintenance director on 09/26/11 at 12:15 p.m. the emergency generator was larger than 100 horsepower. An emergency stop was observed on the generator. At the time of observation the maintenance director was asked if there was a remote emergency		emergency generator remote manual stop. B. Others Identified: 1. The facility has only one generator. C. Measures Taken: 1. The Maintenance Supervisor/designee will audit the proper operation of the remote manual stop during the monthly generator inspections as part of the monthly Preventive Maintenance Program to meet set standards. D. How Monitored: 1. The CEO/designee will review the results of the monthly audits at the quarterly QA & A Committee meetings. E. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is 10/25/2011.	

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	stop for the generator. He said he would shut the gas supply valve to the generator to stop it in the event of an emergency. There was no other remote means to stop the generator. 3.1-19(b)			
K0147 SS=E	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA 70 (National Electrical Code), 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 7 or more resident in the physical therapy smoke compartment. Findings include: Based on observation with the maintenance director on 09/26/11 between 10:00 a.m. and 1:40 p.m., power strip extension cords provided power to an oxygen	K0147	**K-147** It is the intent of this facility to insure that 1 of 1 flexible cords were not used as a substitute for fixed wiring. A. Corrective Action Taken: 1. The power strip extension cord was removed from Room 12. B. Others Identified: 1. All resident rooms were audited to verify that they meet set standards. C. Measures Taken: 1. The Maintenance Supervisor/designee will conduct monthly audits of all resident rooms to meet set standards as a part of the monthly Preventive Maintenance Program. D. How Monitored: 1. The CEO/designee will review the results of the monthly audits at the quarterly QA & A Committee meetings. E. This plan of correction constitutes our credible allegation	10/25/2011

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	concentrator in resident room 12 and a nebulizer and oxygen concentrator in room 76. The maintenance director said at the time of observations, the use of power strips was nor permitted for medical equipment. 3.1-19(b)		of compliance with all regulatory requirements, our date of completion is 10/25/2011.	